

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

Example 3:  
Initial Oral Screening in  
Conjunction with a Health Check Screening

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Brown, Charlie</b>									
3. PATIENT'S BIRTH DATE <b>05 10 01</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>123456789A</b>									
5. PATIENT'S ADDRESS (No., Street) <b>123 Any Street</b>									
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street)									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY <b>11 15 01</b>									
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY <b>12 15 01</b>									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. <b>V20.2</b> 2. _____ 3. _____ 4. _____									
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS OR UNITS H. EPSDT I. Family Plan J. EMG K. COB L. RESERVED FOR LOCAL USE									
1. 11 15 YY 11 15 YY 11 01 99392 BP 80 33 1									
2. 11 15 YY 11 15 YY 11 01 D0150 31 46 1									
3. 11 15 YY 11 15 YY 11 01 D1203 15 44 1									
4. 11 15 YY 11 15 YY 11 01 D1330 15 00 1									
5. _____									
6. _____									
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>09878B</b> 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ <b>142.23</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>142.23</b>									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <b>Bill Jones MD</b> DATE <b>11-15-01</b>									
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <b>Jones Medical Center</b> <b>123 Any Street</b> <b>City, State 29999</b>									
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>Jones Medical Center</b> <b>123 Any Street</b> <b>City, State 29999</b> PIN# <b>8900000</b> GRP# <b>8901000</b>									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0338-0008 FORM CMS-1500 (12-90), FORM RRB-1500,  
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)